Do not staple in this area.

Uniform Medical Plan
Your health. Your plan. Your choice.

Claim Form

Instructions

1. Submit one claim per patient.
2. Attach itemized bills, including patient's name, date of service, diagnosis, and charge.
3. Retirees covered by Medicare who do not have an itemized bill need only attach a copy of the Explanation of Medicare Benefits (EOMB) form. Be sure to complete Section 3 of this form to avoid claims delay.
4. If services were received from a Uniform Medical Plan PPO (UMP PPO) or UMP Neighborhood network provider and either plan is primary (pays before any other plan), you need not file a claim.
5. Mail your completed claim to: **Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850.**
6. This is the correct form to submit a claim for prescription eyeglasses or contact lenses.
7. Do not use this form for prescription drug or dental claims.

Questions? Uniform Medical Plan PPO enrollees: 1-800-762-6004; or 425-670-3000 (Seattle)
UMP Neighborhood enrollees: 1-888-380-2822; or 425-686-1218 (Seattle)

Section 1 Subscriber Information

A. Uniform Medical Plan Subscriber ID No. _____

B. Subscriber Name _____ (Last Name / First Name / M.I.) Birth Date ____/____/____ (Mo. / Day / Yr.)

C. Subscriber Home Address _____ (Street Address)

_____ (City / State / ZIP Code + 4 / Work Phone Number / Home Phone Number)

D. Has your address changed since your last claim? ❑ Yes ❑ No

Section 2 Patient Information *Do not complete if patient is subscriber. Go to Section 3.*

A. Patient Name _____ (Last Name / First Name / M.I.) Birth Date ____/____/____ (Mo. / Day / Yr.)

B. Relationship to subscriber

- ❑ Spouse
- ❑ Dependent child under age 20
- ❑ Dependent stepchild under age 20
- ❑ Qualified same-sex domestic partner
- ❑ Registered student dependent age 20-23
- ❑ Other Specify _____

C. Is patient employed? ❑ Yes, full-time ❑ Yes, part-time ❑ No

If yes: _____ (Name of Employer)

_____ (City / State / ZIP Code + 4 / Employer's Phone Number)

Section 3 Provider Information

Complete this section if the provider information is not included on the bill.

Provider Name	Provider Name
Specialty	Specialty
Address	Address
City / State / ZIP Code + 4	City / State / ZIP Code + 4
Tax I.D. Number (if known)	Tax I.D. Number (if known)

PLEASE COMPLETE REVERSE SIDE

Section 4 Accident or Work-Related Injury Information

A. Is this claim the result of a work-related illness or injury? ❑ Yes ❑ No

B. Is this claim due to any accident or injury? ❑ Yes ❑ No
If you answered no to both questions, go to Section 5.

C. Was illness or injury due to ❑ Auto accident ❑ Other Specify _____

D. Date accident occurred _____/_____/_____
Mo. Day Yr.

E. Was a police report filed? ❑ Yes ❑ No ***If yes, you must submit a copy of the police report with this claim.***

F. Explain where and how the illness or injury occurred _____

_____

G. Your auto or homeowner's insurance company _____
Name of Insurer

_____
Street Address City State ZIP Code + 4 Phone Number

H. Insurance company of another party involved with this loss _____
Name of Insurer

_____
Street Address City State ZIP Code + 4 Phone Number

I. Do you intend to seek repayment of medical expenses or work time lost for you or your dependent?
❑ Yes ❑ No ❑ Uncertain at this time

J. Will you file for any disability benefits? ❑ Yes ❑ No ❑ Uncertain at this time

K. Will you contact an attorney in this matter? ❑ Yes ❑ No ❑ Uncertain at this time

L. If yes _____
Name of Attorney Phone Number

Section 5 Other Coverage

A. Are patient's medical expenses covered by another employer's group health insurance, welfare, or government plan? ❑ Yes ❑ No
If yes, and the other plan is primary, attach a copy of the Explanation of Benefits from the other plan to expedite processing.

If yes, name of policyholder on other coverage _____
Name

_____
Street Address City State ZIP Code + 4

_____
Name of Plan Group Number

B. Is patient covered by Medicare? ❑ Yes ❑ No
If no, go to Section 6. If yes, please submit a copy of the Explanation of Medicare Benefits.

C. What type of Medicare coverage does patient have? ❑ Part A (Hospital) ❑ Part B (Physician)

If patient is under age 65:

D. Is Medicare coverage due to kidney disease? ❑ Yes ❑ No

E. Is Medicare coverage due to disability? ❑ Yes ❑ No

Section 6 Authorization to Pay

Have you paid for these charges? ❑ Yes ❑ No ***UMP pays network providers directly.***

I certify this information is correct and authorize its release as required for administration of this claim.
Please note that personal information you may be required to submit to the Uniform Medical Plan, including medical records, will be disclosed only according to guidelines in the UMP *Notice of Privacy Practices*, which is available on the UMP Web site at **www.ump.hca.wa.gov**, or by calling customer service (see page 1).

_____ _____
Signature of Subscriber/Patient (Parent, if minor) Date